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ABSTRACT

The fact that many states have passed elder abuse reporting laws has left care providers with a dilemma. If suspected abuse is reported, the relationship between caregiver and patient may change and the family's difficulties may increase. Indicators of abuse are not easy to differentiate from health problems, especially in the frail elderly. An Elder Assessment Team was established at Beth Israel Hospital to develop a protocol to use in assessing potential abuse. The elder assessment instrument was developed to assess the following areas on a Likert scale: (1) general physical presentation; (2) physical condition; (3) usual life style; (4) social interactions; and (5) medical conditions. Following this protocol, clinicians judge whether they see evidence of abuse and a care team of nurse, physician, and social worker assess and dispose of the case, filing a report with authorities if necessary. Staff awareness of elder abuse has been increased since the implementation of this protocol and staff seem more willing to report their suspicions to an internal group than to file a state agency report. (The Elder Assessment Instrument is appended.) (ABL)

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PROCTOCOLS FOR THE ASSESSMENT OF ELDER ABUSE

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Introduction

An important correlate of caregiver stress is elder abuse. In an effort to respond to concerns about elders who are vulnerable to abuse, States have passed a variety of elder abuse "reporting" laws which encourage or require professionals and lay public to report cases of suspected abuse and neglect. Implementation of such legislation has raised difficult philosophical and practical questions for professionals and service-providing institutions, which encounter individuals with conditions or injuries that might have been caused by abuse or neglect. How do institutions such as hopsitals and other care facilities respond to such reporting laws? How are staff helped to recognize signs and symptoms of abuse or neglect and how are they encouraged to report suspected cases.

A report of suspected abuse or neglect is not a trivial matter. Care providers are concerned that the investigation that follows such a report may interfere with the care-taker/patient relationship, may exacerbate family

difficulties, and are certainly likely to alter the relationship between the reporter and the suspected abuser. These concerns lead to a reluctance to make official reports of suspected abuse.

In a like manner, many reporting laws are either vague or overly specific in their definition of abuse or neglect, leading to confusion on the part potential reporters. The signs and symptoms of abuse or neglect are not always easily differentiated from conditions related to other health problems, particularly in very frail and multiply-impaired elders.

In order to respond to these concerns, an Elder Assessment Team was initiated at Beth Israel Hospital in Boston, Massachusetts. The purpose of this Team was to address the problem of elder abuse, to respond to the new state reporting laws (Chapter 479 and Chapter 604), to encourage staff to report cases of suspected abuse or neglect, and to assess cases of suspected abuse and neglect prior to a formal report. The team decided early on that the development of a protocol to be used in assessing potential cases of abuse and neglect was an important first step.

The purposes of the protocol were multiple. First, it would raise awareness of elder abuse by identifying categories of signs and symptoms, and by encouraging staff to review every high risk patient upon entry into the hospital. Second, it would provide a systematic format for examining the patient for signs and symptoms. Third, it would increase the willingness of staff to identify to the Team cases of suspected abuse or neglect, recoginizing that the Team would investigate the cases before a formal report was filed. Fourth, the protocol would provide information to be used in the evaluation of team function. And finally, data collected via the protocol would be available for research.

The purpose of this paper is to report the process of developing the protocol, to describe its content, and to briefly evaluate its use and effectiveness in meeting the goals described above. The applicability of this protocol to other settings will also be discussed.

Content and Format

The elder assessment instrument (EAI), (Appendix I) is an inter-disciplinary assessment instrument which reflects the dominant themes in the elder abuse literature

such as dependency in old age, stressed care providers, and high risk indicators for abuse and neglect.

The first pilot instrument utilized at the Beth Israel was a narrative, open-ended form which required the clinician to make judgments about the presentation of the elders they cared for. Since it was lengthy, clinicians found it difficult to use in their daily practice, so a second instrument was constructed which utiilized a one-page checklist on a "good-fair-poor" scale. While useful, this scale made it impossible to determine the meaning of "fair." A 3rd revision was made which utilized a likert scale format. This format continues to be used today. The eight sections of the instrument plus the outcome summary are as follows:

General Assessment: This section reviews the elders general physical presentation - their clothing, hygiene, nutrition and skin integrity. An area is provided for any additional comments the clinican may want to add.

The Physical Assessment section evaluates the presence of absence of common clinical symptoms of elder abuse. This list was the result of three independent trials and the assessment factors listed were noted to be the most common symptoms listed during assessment.

The Usual Lifestyle section elicits dependency factors which may be the source of stress for caregivers.

The Social Assessment evaluates the quality of personal interactions between the elder and his or her careprovider as well as an evaluation of support systems and the elders ability to express his or her needs.

The Medical Assessment section provides a list of unacceptable medical conditions which should be evaluated for causative factors.

The Summary Assessment asks the clinicans to make a judgment as to whether or not they believe there is evidence of elder abuse.

A Disposition Section enables the team to document follow-up on each of the referred cases.

The elder assessment instrument is now used routinely at the Beth Israel to evaluate any individuals who are referred for suspected abuse, neglect or mistreatment. Once an assessment is initiated, a three-member core-group consisting of a nurse, physician and social worker do an indepth assessment in order to make recommendations to hospital administration regarding the necessity of a state agency report. In the initial phase of the project, all assessments were reviewed by an eleven member interdisciplinary team. Over time, it has

evolved to the current 3 person evaluation which is more efficient. The larger group meets on a quarterly basis in order to review policy and discuss in-service needs at the hospital.

Clearly, there is a new level of awareness in the staff at Beth Israel of the possibility of elder abuse. The assessment instrument has been incorporated into the emergency unit staff orientation and the topic of elder abuse is a regular part of staff education programs for all disciplines. Staff seem less reluctant to report suspected cases to an internal group as opposed to state agencies, and hospital administrators work closely with the group for the purpose of providing support for this difficult area of assessment.

Data continue to be collected through this assessment instrument which will hopefully provide important information on this serious topic.

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Emergency Unit Form #81-12-04-076
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ELDER ASSESSMENT

Office Use Only

Date _____ Person Completing form _____

Payment Status (Please check one):
_____BlueCross/Blue Shield _____Medicaid
_____Medicare _____Private Payment _____Other

Residence (Please check one):
_____Home _____Name of Nursing Home
_____Other (e.g., son/daughter's home)

Accompanied by: _____Family _____Friend _____Alone
_____Nursing Home Personnel

Reason for Visit: _____Cardiac _____Changed Mental Status
_____Fall _____G.I. _____Orthopedic
_____Other (please state) _____

Current Mental Status: _____Oriented _____Confused
_____Unresponsive

_____HRCA _____AGE

1. GENERAL ASSESSMENT

	Very Good	Good	Undecided	Poor	Very poor	No basis for Judgement
a. Clothing						
b. Hygiene						
c. Nutrition						
d. Skin integrity						

Additional Comments: _____

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2. PHYSICAL ASSESSMENT

	Definite Evidence	Probable Evidence	Uncertain	Probably no Evidence	No evidence	No basis for Judgement
a. Bruising						
b. Contractures						
c. Decubiti						
d. Dehydration						
e. Diarrhea						
f. Impaction						
g. Lacerations						
h. Malnutrition						
i. Urine burns/excoriations						

Additional Comments: _____

3. USUAL LIFESTYLE

	Totally Independent	Mostly Independent	Uncertain	Mostly Dependent	Totally Dependent	No basis for Judgement
a. Administration of medications						
b. Ambulation						
c. Continence						
d. Feedings						
e. Maintenance of hygiene						
f. Management of finances						
g. Family involvement						

Additional Comments: _____

4. SOCIAL ASSESSMENT

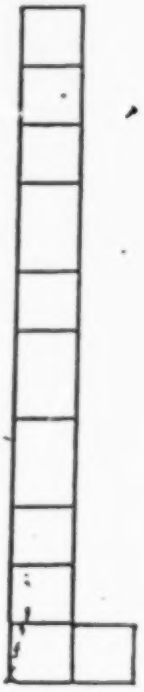
A. Narrative statement regarding patient-identified social problems: _____

_____

B. Family/nursing home perception of problem: _____

_____

	Very good quality	Good quality	Uncertain	Poor quality	Very poor quality	No basis for judgement
a. Financial situation						
b. Interaction with family						
c. Interaction with friends						
d. Interaction with nursing home personnel						
e. Living arrangement						
f. Observed relationship with care provider						
g. Participation in daily social activities						
h. Support systems						
i. Ability to express needs						



Additional comments: (recent changes in life situation) _____

_____

_____

_____

_____

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5. MEDICAL ASSESSMENT

	Definite evidence	Evidence	Possibility	Probably no evidence	No evidence	No basis/Not applicable
a. Duplication of similar medications (e.g., multiple laxatives, sedatives)						
b. Unusual doses of medication						
c. Alcohol/substance abuse						
d. Greater than 15% dehydration						
e. Bruises and/or fractures beyond what is compatible with alleged trauma						
f. Failure to respond to warning of obvious disease						
g. Repetitive admissions due to probable failure of health care surveillance						

(Attach description of any additional physical findings)

Additional comments: (Note: if either 5a or 5b has been answered in the affirmative, please elaborate and be as specific as possible) _____

6. SUMMARY ASSESSMENTS

	Definite evidence	Evidence	Possibility	Probably no evidence	No evidence	No basis/Not applicable
a. Evidence of financial/ possession abuse						
b. Evidence of physical abuse						
c. Evidence of psychological abuse						
d. History of recent life crisis						

Additional comments: _____

7. DISPOSITION

	Yes	No
a. Referral to Elder Assessment Team		
b. Referral to Clinical Advisor		

8. GENERAL COMMENTS: (Nursing home contact person and date) _____

_____

_____

_____

_____

_____

Summary Statement in regard to Abuse/Neglect/Mistreatment and follow-up plan.

Date _____ _____ R.N.

_____ M.S.W.

_____ M.D.